BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **HARA P. MISRA, M.D.** Holder of License No. **14933** For the Practice of Allopathic Medicine In the State of Arizona.	Board Case No. MD-02-0713A **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** (Letter of Reprimand)

The Arizona Medical Board ("Board") considered this matter at its public meeting on August 11, 2004. Hara P. Misra, M.D., ("Respondent") appeared before the Board with legal counsel Michael Bradford for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue the following findings of fact, conclusions of law and order after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 14933 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-02-0713A after receiving a complaint regarding Respondent's care and treatment of a 72 year-old female patient ("EH").

4. EH's primary care physician had performed a CT scan on March 15, 2000 that showed an infiltrating malignancy of the omentum into the right pelvic region, also potentially involving the colon. EH also had significant ascites at that time. A chest and abdominal x-ray taken at this same time were read as normal. EH was referred to

Respondent in March of 2000. EH related to Respondent a history of pelvic pain and abdominal discomfort of two years duration with diarrhea and constipation.

5. On April 6, 2000 Respondent admitted EH to Boswell Hospital ("Hospital"). Respondent recommended an exploratory laparatomy and evaluation of the abdomen. Respondent's operative note indicates that the potential procedure was discussed with EH and her family. At the time of surgery Respondent noted that EH had extensive carcinomatosis with 2500 ccs of ascites. In his initial response letter to the Board Respondent described a "frozen pelvis." However, his operative note does not specifically mention a frozen pelvis. Respondent's operative note states that both ovaries look tumorous, mostly on the left side in comparison to the right, but noted that it was hard to differentiate in terms of the presence of a tumor at this site. Respondent noted that EH had massive omental metastasis and metastasis to the side walls of the abdomen and the appendix. Respondent undertook an appendectomy, omentectomy, and a repair of a minor tear of the serosa of the colon and performed a debulking procedure. There was no clarification in Respondent's operative note of the cancerous ovaries or the amount of residual tumor that was left. In his initial response letter to the Board, Respondent indicated that further attempts at pelvic surgery would have been hazardous to EH because she had not had a bowel preparation done and because the pelvis was so involved with tumor.

6. EH had a normal post-operative course and was discharged from Hospital in good condition. The final diagnosis as a result of the surgery Respondent performed was a poorly differentiated papillary serous carcinoma of the ovary. In addition, EH was to be staged as Stage III ovarian cancer. While still hospitalized, EH was referred to a medical oncologist who undertook her care and initiated the chemotherapy protocol.

7. In May 2001 EH was again experiencing discomfort and presented to a gynecologic oncologist. A CT scan of the pelvis ordered by the medical oncologist and performed on April 6, 2001 showed a 5.9 cm x 5.6 cm right adnexal mass compatible with ovarian neoplasm that demonstrated an increase in size since the original March 15, 2000 CT scan. The left ovary had also increased in size and a small amount of free ascites was reported. Also, a gallstone was found with a small ventral hernia and bilateral renal cysts were noted as incidental findings. On May 8, 2001 the gynecologic oncologist performed an exploratory laparatomy with bilateral salpingo-oophorectomies, tumor debulking, partial omentectomy, diaphragmatic biopsies, and pelvic and periaortic lymphadenectomies. The lymph nodes were all benign, but there was again extensive tumor present in the ovaries bilaterally and into the fallopian tubes and peritubal tissues. The pelvic sidewalls and mesentery again showed metastatic tumor, as did biopsies to the diaphragm. The gynecologic oncologist wrote in his operative note that the pelvis was partially frozen at that time.

8. EH started chemotherapy again and did well for a period of time. She subsequently suffered from her malignancy and was hospitalized on a couple of occasions to remove ascites from her abdomen and to attempt to keep her comfortable. EH was placed in hospice care at the end of October 2002 and expired shortly thereafter.

9. Respondent testified that for the past year he was no longer performing gynecological surgery and that he had submitted to the Board cases that he had performed successfully in the past to illustrate his efficiency and qualification to do gynecological surgery. Respondent noted that with EH there was no definitive mention of the ovarian origin of the mass in the CT scan. Respondent testified that he was noting this for the Board because, if it was obvious that it was an ovarian cancer, it is his training and practice to refer the case to a gynecological oncologist/surgeon rather than handling

it himself. Respondent noted he would do so because such a physician would do better in terms of this surgery, not because Respondent is not qualified, but because such a surgeon would have done more cases and would be more comfortable doing the surgery. Respondent noted that because he believed EH had an abdominal mass, he did the surgery himself.

10. Respondent noted that his operative findings were massive ascites with more than 2500 ccs of peritoneal fluid with omental metastatic tumors linked to the wall of the large intestine, as well as the peritoneal wall along the floor of the pelvis with the tumor metastasis. Respondent added that even though there was a suggestion from the radiologist that a preoperative peritoneal biopsy could give a tumor mass diagnosis, he did not do one because of the strong literature view that in the face of ascites, the paracentral abdominal tap is contraindicated. Also, there was no reason for him to do a bowel resection in EH because there were no obstructive symptoms and she was very sick, with severe nausea, vomiting and diarrhea for two years duration.

11. Respondent noted that the procedure included the removal of the omental tumor and multiple biopsies along with the tumor debulking as much as possible. Respondent testified that, rather than becoming too aggressive to cause the bleeding and a total tumor debulking, he stopped short of the surgery when he saw a massive frozen pelvis with hardly the differentiation of the ovaries in the pelvic floor. Respondent stated that the removal of the ovaries at this time would have created a complication since they have simply started in the pelvic floor with tumor metastasis, Stage III (as noted in the operative report.) Respondent stated he did not remove the ovaries keeping in mind that EH would undergo another tumor debulking surgery as soon as she recovered and as soon as the oncologist and primary care physician felt it was safe. Respondent noted that EH followed with him in his office in April 2000, approximately ten days after the

surgery. EH was doing well and Respondent mentioned that if there was any surgical complication she should return to him as soon as possible.

12. Respondent was asked to state his differential diagnosis in March of 2000, after having reviewed the CT scan and meeting with EH. Respondent stated that abdominal mass or interpreter tumor is always a myth and that he wished he could know exactly the tumor diagnosis prior to the exploratory laparatomy. That is the reason it is written as "explore lap" rather than a particular tumor resection. Respondent stated that the tumors are considered multiple, including the colonical origin carcinometatasis, the pancreatic serocyst tumor metastasis, the omental primary tumor itself, and metastasis from other unknown origins. And that also includes the tumor of the pelvis, the original adnexal, which also includes the ovary.

13. Respondent was asked if he considered the work-up suggested by the radiologist – the biopsy of the omentum, not a paracentesis – in furthering his differential diagnosis. Respondent said that he did and that the omental biopsy that was suggested by the radiologist was to the middle which will go through the abdominal wall through the ascetic side, through the omental mass. Respondent noted that the American College of Obstetrics and Gynecology ("ACOG") Journal mentions that such an investigational test prior to surgery is contraindicated. The Board noted that the ACOG Journal said that paracentesis is not indicated, not that it is contraindicated. Respondent was asked what other preoperative testing he considered that would have helped him differentiate the type of tumor. Respondent noted that one may consider tumor evaluation, but that is mostly not specific, including the CA125 or CEA. Respondent was asked if that would have helped him differentiate from the other etiologies he was describing. Respondent stated that the differential diagnosis would not change with the CEA finding and could

have with the CA125, but that again is a tumor marker, which is glycoprotein and most of the time it is done in the postoperative period with chemotherapy.

14. Respondent was asked if in hindsight it would have been helpful to have a CA125 preoperatively so he could monitor the decreasing or increasing levels postoperatively. Respondent noted that EH's CEA125 was done by her primary physician on the 8th of March and the level was normal. Respondent noted that although this was different from the CA125, both are tumor markers and the glycoproteins are ovarian carcinos. Respondent was asked why, since the CT scan indicated there was infiltration of the colon, a bowel preparation was not indicated. Respondent stated that EH was very sick and because he was not resecting the bowel, the bowel preparation was not necessary. Respondent noted that he has done bowel preparation in routine gynecological surgery where he knows there is an ovarian tumor.

15. The Board noted that in his pre-operative diagnosis Respondent made note of possible ovarian tumor. Respondent was asked why, since he was entertaining the possibility that this was an ovarian malignancy, he did not do the bowel preparation and tumor markers. Respondent stated that tumor markers are not specific so one cannot pinpoint that "because there is an ovarian tumor this tumor marker is high." Respondent stated that even though the tumor was advanced to Stage III, the CEA was normal and this confirms his impression that a tumor marker prior to surgery is a nonspecific marker.

16. Respondent was asked to clarify whether he had partially resected the tumor mass from the ovaries because the Board was unable to verify this from the operative note. Respondent stated that the operative note clearly describes what he did and did not do and that the frozen pelvis, the tumor, only the biopsy was done. Besides that, the tumors that were removed were the omental cake appendix and the shaving of the colon and the frozen wall of the small intestine and large intestine. Respondent

stated that when he mentioned there was the tumor started in the pelvis that was not removed, that is what was left, along with the other tumor reseedables.

17. Respondent was asked what the diagnosis of the frozen section of the omental cake, specifically, a differentiated papillary serous carcinoma, made him think of in terms of primary etiology. Respondent stated that he thought of ovarian cancer. Respondent was asked if he then considered a gynecologic oncology consult intraoperatively. Respondent stated that he did and that he discussed this with another physician, but there was no gynecologic oncology surgeon available at that time at Hospital. Such a surgeon needed prior notice. Respondent was asked whether, with his preoperative concern about an ovarian tumor, he would have considered having a gynecologic oncologist there prior to the surgery or assisting him with the surgery. Respondent stated that once the diagnosis was confirmed in terms of CT scan he would have definitely sent EH to a gynecological oncology surgeon.

18. Respondent was asked to explain the complications he was concerned about that caused him not to debulk the frozen pelvis. Respondent testified that most important was bleeding and injury to other adjacent organs, including the ureter or the large or small intestine. Respondent was asked if, when going in for a potential ovarian malignancy, a surgeon should be prepared for those things and be able to dissect out the ureter and repair the bowel. Respondent stated the he was going in for an abdominal tumor so he was not prepared for a gynecological oncology definitive surgery.

19. At the conclusion of the Board's questions, a Staff Medical Consultant noted that although Respondent stated there was no elevated CEA 125, EH's records indicate that on April 11, 2000, about six days after the surgery, there was a CEA125 drawn at Hospital of 277, with the upper normal being 35.

20. The standard of care required an adequate preoperative evaluation that would not have compromised the initial surgical procedure, including a consultation with a gynecological oncologist.

21. Respondent fell below the standard of care because did not conduct an adequate preoperative evaluation, including a consultation with a gynecological oncologist and this compromised EH's initial surgical procedure.

22. EH was subject to potential harm because she was deprived of a potentially better outcome.

CONCLUSIONS OF LAW

1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

3. The conduct and circumstances described above constitutes unprofessional conduct pursuant to A.R.S. § 32-1401(27[1])(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the patient or the public.")

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED that Respondent is issued a Letter of Reprimand for an inadequate preoperative evaluation that compromised the patient's initial procedure.

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[1] Formerly A.R.S. § 32-1401(26). Renumbered effective August 25, 2004.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board within thirty (30) days after service of this Order. A.R.S. § 41-1092.09. The petition must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-102. Service of this order is effective five (5) days after date of mailing. If a motion for rehearing or review is not filed, the Board's Order is effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED this 10th day of November, 2004.

ARIZONA MEDICAL BOARD 1913 STATE OF ARIZONA

THE ARIZONA MEDICAL BOARD

By _____
BARRY A. CASSIDY, Ph.D., PA-C
Executive Director

ORIGINAL of the foregoing filed this 12th day of November, 2004 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing mailed by U.S. Certified Mail this 12th day of November, 2004, to:

Michael Bradford
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Executed copy of the foregoing
mailed by U.S. Mail this
Dth day of November, 2004, to:

Hara P. Misra, M.D.
Address of Record.